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No. 85-1385

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

UNITED STATES OF AMERICA,

Petitioner,

v.

GENERAL DYNAMICS CORPORATION, GENERAL DYNAMICS LAND SYSTEMS, INC. (formerly called Stromberg-Carlson Corporation), DATAGRAPHIX, INC., MATERIAL SERVICE CORPORATION and MARBLEHEAD LIME COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether an accrual-basis taxpayer providing medical benefits to employees under uninsured medical benefit plans may deduct in 1972 its liability for medical services received in 1972 by employees but unpaid by the end of the year.

STATEMENT REQUIRED BY RULE 28.1

Respondents have the following affiliated corporations, companies and partnerships: Lachmar Partnership; Mansour-G.D. Ltd.; Mines SNA, Inc./SNA Mines, Inc.; Etudes Techniques et Constructions Aerospatiales, Societe Anonyme; Tusas Aerospace Industries, Inc.; and Continental Cement Company. Respondents have no other parent corporation and no other subsidiary which is not wholly owned.

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STATEMENT OF THE CASE

The issue in this case is the proper timing for the deduction by these accrual-basis taxpayers of their liability for medical benefits received by employees.

For many years, taxpayers have provided medical benefits to their employees and their employees' dependents

for non-occupational sickness and injuries. In October, 1972, taxpayers stopped purchasing group health insurance and commenced providing these medical benefits directly. As direct providers of these benefits, taxpayers bore the liability for and paid the medical benefits.

These expenses were clearly deductible; the issue is only one of timing: should the expenses for medical services received by employees in 1972 be deducted in 1972 or a later year. The proper timing for accrual-basis taxpayers was governed by the "all events" test, Treasury Regulation § 1.461-1(a)(2): a liability must be deducted in the year in which all events have occurred which determine the fact of liability.* Payment of an expense by year-end was not required.

In the Claims Court, taxpayers presented substantial evidence showing what the medical benefit plans were and how they operated. In addition to documents and stipulated facts, taxpayers presented three witnesses on this issue: their Director of Employee Benefits, who was in charge of the medical benefit programs from 1970 to 1980; and two medical benefit professionals, each with 23 years of extensive experience in medical claim processing and group medical benefit plan administration. (Tr. 44-46, 70-74; PX 47 at 4-9.)** Taxpayers' evidence was both unrebutted and uncontradicted. Indeed, the government of-

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* The "all events" test has a second element which must also be satisfied: the amount of the liability must be determinable with reasonable accuracy. Both the trial court and the appellate court found that the second element had been met, and the government does not seek review of that issue here. (Petition 13 fn. 2.)

** References are as follows: "App." refers to the Appendix to the Petition for a Writ of Certiorari; "C.A. App." refers to the Appendix in the Federal Circuit; "PX" refers to Plaintiffs' Trial Exhibit; "Tr." refers to the trial transcript. PX 47 was offered and received in evidence at Tr. 42.

fered no witnesses at all. The government's Petition for a Writ of Certiorari completely ignores these witnesses and the substance of this uncontradicted evidence. Instead, the government substitutes its own notions of the nature of the medical benefits, describing them in such a way as to make them appear to be estimates of future contingent liabilities. Of course, ignoring the record is improper, and substitution by the government of its own view of the facts is unwarranted.

After hearing and considering the extensive evidence, the trial court found that taxpayers' liability attached upon the receipt of medical services by their employees and did not await the completion of the routine and clerical processing of the claim forms for payment. (App. 12a-13a, 15a.) Based upon the evidence, this finding was clearly correct.

Specifically, the evidence showed that the plans provided basic medical benefits and major medical benefits. (Tr. 46-47, 78-79; C.A. App. 19; PX 47 at 9-10.) The basic medical benefits included hospital costs (primarily room and board charges), doctors' fees for surgery, costs for anesthesia and other medical services. The basic plan paid 100% of covered items up to specified limits (*e.g.*, $60 per day for a hospital room). The major medical benefits provided for costs exceeding those covered by the basic medical plan, as well as certain additional items (*e.g.*, prescription drugs). The major medical plan had an annual deductible and then paid for costs on a shared basis (*e.g.*, the taxpayers paid 80% and the employees, 20%). Each plan described in detail the persons covered and the exact nature and extent of the benefits provided. (C.A. App 19, 47-73.)

Taxpayers provided these medical benefits to their employees as part of the consideration for the employees'

services. (Tr. 51; C.A. App. 15.) Taxpayers promised their employees that these benefits would be paid. (Tr. 46-47, 51; C.A. App. 15.) Booklets describing the plans were distributed so employees were fully informed of the benefits to which they were entitled. (C.A. App. 19-20; 47-73; Tr. 49-50.) Taxpayers' liability for the medical benefits was a matter of contract; liability did not depend upon any determination of fault or wrongdoing. (C.A. App. 24, 47-73.)

Furthermore, under the plans, taxpayers' general contractual liability to provide benefits became fixed as to particular medical expenses of specific employees at the time the medical services were received by the covered individual. (Tr. 51, 116, 139, 217-218.) At that time, all conditions to the basic liability had occurred: (1) the person receiving the services was covered by the plan, (2) the services were covered by the plan, and (3) the services had been performed. At that time, the employee had a vested right to his benefits.

All witnesses testifying on the subject agreed that under taxpayers' plans, the critical time for fixing of liability for specific benefits was when the services were received, not when claims for payment were filed and processed. Once services had been received, taxpayers could not avoid liability for such services by terminating the plans; claims processed after termination of a plan for services received prior to plan termination would have to be paid. (Tr. 52-53, 117.) Similarly, termination of an employee's employment did not extinguish taxpayers' liability for services received prior to termination, even if the claim form was filed afterwards. (Tr. 51-52, 116-117; PX 47 at 55-56.)

To obtain payment for medical services received, employees submitted claim forms, which underwent a rou-

tine, standardized processing procedure and were paid according to the benefit schedules contained in the plans. (C.A. App. 21; Tr. 53-55, 79-85; PX 47 at 15-20.) Completed forms with supporting documentation, such as doctor's and hospital bills, were submitted. (C.A. App. 21; PX 10, Tr. 33-34, 39-40; Tr. 53-54.) A simple clerical check was made to verify that the person receiving services was covered at the time of treatment. (Tr. 55, 79-80; PX 47 at 15-16.) The forms were then processed by matching the claims against the plans to calculate and pay the amounts due. (Tr. 54-55, 80-85; PX 47 at 16-20, 23; C.A. App. 22.)

The benefit calculations were made expeditiously by experienced claim processors on a large volume basis, pursuant to the provisions and schedules of the plans, augmented by guidelines and routine procedures established by Aetna Life Insurance Company ("Aetna") and The Prudential Insurance Company of America ("Prudential").* (C.A. App. 21, 23; Tr. 76-78, 79-81, 85-87; PX 47 at 14-15, 20-25.) The processors matched the claim data against the detailed provisions of the particular plan. The processors excluded amounts which were not covered at all (such as a hospital meal for a patient's guest and television rental charges on hospital bills), calculated basic medical benefits, and then calculated the major medical benefits.** (Tr. 54,

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* The taxpayers hired Aetna and Prudential to administer the plans when taxpayers took over direct liability for the medical benefits. (C.A. App. 18.)

** In most instances, all necessary data was contained in the papers when the processors received them. In those instances where additional data was necessary, rather than reject the claim, the missing data was obtained, usually by telephone or letter to the employee, doctor or hospital, as the case might be. (Tr. 99-100; PX 47 at 39-41; C.A. App. 21.) Then the processing would be completed.

80-85; PX 47 at 16-23; C.A. App. 22.) This processing was routine and clerical. Approximately 95% of the claims were handled by the regular processors and only 5% required consideration by more experienced supervisors, still in a routine manner. (PX 47 at 24-25; Tr. 85-87.) The witnesses described in detail how specific types of circumstances such as coinsurance (Tr. 104-109; PX 47 at 41-48), preexisting conditions (Tr. 109-112; PX 47 at 36-39), prevailing rates (Tr. 88-93; PX 47 at 33-36), and work-related injuries (Tr. 67-69; PX 47 at 51-52) were handled in routine fashion.

While employees did not receive actual payment for benefits until a claim form was filed and processed, all of the events which determined the fact, as well as the amount, of the liability had occurred prior to the filing of the form. If a claims processor had been at the hospital on the day an employee was discharged, the processor could have processed and calculated the amount of the medical benefit at that time. (Tr. 69, 102-103.)

Disputes regarding medical benefit payments were virtually nonexistent. (Tr. 55-57, 60.) By their very terms, the plans did not purport to pay 100% of all medical costs. (Tr. 47; PX 47 at 50; C.A. App. 47-73.) Employees did not themselves calculate the amount due; instead, they submitted their bills, and the processors made the calculations. Consequently, failure to pay items not covered by the plans did not give rise to a dispute. The philosophy applied in processing the claims was to pay everything which was due. (Tr. 59-60, 102; PX 47 at 56.) Mr. Hawkins, taxpayers' Director of Employee Benefits, testified that he could recall no lawsuits regarding medical benefits in the 10-year period from 1970 to 1980. (Tr. 57.) This was supported by Mr. Schaal of Prudential, who testified that he could recall only two lawsuits regarding taxpayers'

medical benefit plans in the period from 1969 to 1983.* (PX 47 at 53-54.)

SUMMARY OF ARGUMENT

Having failed to offer any evidence to rebut taxpayers' evidence demonstrating that their liability under the medical benefit plans was established by the end of 1972 for all employees who received medical services during 1972, the government properly lost this case in both of the lower courts. On the basis of the uncontradicted evidence and well-established legal standards, the trial court found that the fact-of-liability portion of the "all events" test was clearly satisfied in 1972. Ignoring the evidence and the findings, the government now seeks to conjure up a purported conflict with principles established by this Court and other circuit courts. In fact, no such conflict exists. The lower courts in this case neither departed from settled principles of this Court nor came to conclusions at odds with other circuits. The lower courts merely applied the established law to the proven facts of this case.

The cases cited by the government merely illustrate the well-settled rule that contested liabilities or contingent liabilities (which will arise only upon the occurrence of future events) do not satisfy the "all events" test. For

* This absence of disputes concerning the taxpayers' medical benefit plans was corroborated by the insurance companies' own general experience. Aetna had only 129 lawsuits in 1979 when it made over 16,000,000 claim payments and only 199 lawsuits in 1982 when it made over 33,000,000 claim payments. (Tr. 118-120.) Prudential had 96 lawsuits in 1982 in relation to 450,000,000 claim payments. (PX 47 at 54.)

example, in this case, taxpayers would be precluded by this rule from deducting in 1972 their estimate of the amount of medical benefits they would be required to pay for medical services to be received by employees in 1973. Here, however, the deduction at issue relates to liabilities which had already accrued because of the receipt of medical services by specific employees in 1972. The evidence shows that those liabilities are neither contingent nor contested. The cases starting with *United States* v. *Anderson*, 269 U.S. 422 (1926), which gave birth to the "all events" test, establish that ministerial processing of forms does not delay fixation of liabilities under that test. In short, the evidence and findings establish conclusively that the processing was ministerial, and the well-settled case law establishes that ministerial processing does not preclude a deduction.

Many of the arguments made by the government are irrelevant red herrings. Since the record established that the "all events" test has been satisfied, it is irrelevant what liabilities insurance companies are permitted to deduct or that Congress enacted in 1954, and shortly afterward repealed, a provision allowing taxpayers to deduct certain liabilities that did not satisfy the "all events" test. Also, the fact that certain reserves dictated by prudent accounting principles cannot be deducted if they do not satisfy the "all events" test has no relevance to this case in which the requirements of that test are satisfied.

Finally, this is not a medical benefit test case or a case in which the lower courts have broadly held that all claims for medical benefits are deductible. The lower courts have merely found, quite properly, that the record in this case demonstrates that the deductions at issue here satisfy the well-established criteria of the "all events" test. This case does not merit review by this Court.

ARGUMENT

I. THERE IS NO CONFLICT WITH THE DECISIONS OF THIS COURT.

From the inception of this case, the parties and the courts have agreed that the timing of the deduction for these accrual-basis taxpayers was governed by the "all events" test, which was first enunciated in *United States* v. *Anderson*, 269 U.S. 422 (1926), and was later set out in Treasury Regulation § 1.461-1(a)(2). Under the relevant portion of the test, the taxpayers must deduct a liability when all events have occurred which determine the fact of liability. As a corollary, a deduction is not allowed while a liability is either contingent or contested by the taxpayer. *Brown* v. *Helvering*, 291 U.S. 193 (1934); *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516 (1944).

The cases cited by the government are inapposite to the instant case. For example, *Brown* v. *Helvering*, *supra*, disallowed a proposed deduction for commission refunds which might have to be made by an insurance agent if policies were cancelled in the future. This is a typical situation of a contingent liability which might arise depending upon the occurrence of future events (there, cancellation of policies). In *American Automobile Ass'n* v. *United States*, 367 U.S. 687 (1961), this Court concluded that the taxpayer, an automobile club, could not defer membership income which it had already received on the ground that it would be required to provide services to members upon request over a future period of time. Again, this was a contingent matter dependent upon the occurrence of future events: the events which would cause members to request service had not yet occurred, and the members had, therefore, not requested service. *Dixie Pine*

Products, supra, involved a contested liability, as did *Lucas* v. *American Code Co.*, 280 U.S. 445 (1930), and *Security Flour Mills Co.* v. *Commissioner*, 321 U.S. 281 (1944).

Neither court in this case disagreed with or refused to follow established principles of this Court on this issue. Neither court in this case formulated the applicable law in a fashion which conflicted with established law in opinions of this Court. Neither court in this case held or suggested that contingent or contested liabilities were presently deductible. Instead, based upon the evidence adduced by taxpayers and unrebutted by the government, the trial court found that the events which established the fact of taxpayers' liability (that is, the receipt of medical services by employees) had occurred by the end of 1972, and thus deduction of the liability in 1972 was required. Rejecting the government's argument that the liability in this case was contingent at year-end, the trial court properly found that the liability was fixed and certain. These decisions are clearly consistent with the decisions of this Court.

II. THERE IS NO CONFLICT IN THE DECISIONS AMONG THE CIRCUITS.

A second argument by the government is that the decision of the Federal Circuit below conflicts with three decisions by other circuit courts: *Trinity Construction Co.* v. *United States*, 424 F.2d 302 (5th Cir. 1970), *Bennett Paper Corp.* v. *Commissioner*, 699 F.2d 450 (8th Cir. 1983), and *World Airways, Inc.* v. *Commissioner*, 62 T.C. 786 (1974), *aff'd*, 564 F.2d 886 (9th Cir. 1977). This argument is preposterous since the mere reading of the government's description of these cases in the Petition for a Writ of Certiorari clearly distinguishes them.

Each of these three cases followed the general rule that a liability whose existence is contingent upon the occurrence of an event in the future is not deductible before the contingency occurs. In *Trinity Construction*, an employer was obligated to pay premiums on life insurance policies for certain employees but only if the particular employee was alive when the premium was due. In *Bennett Paper*, a company was obligated to pay bonuses in later years, but only if the employee was still employed when the payment came due. In *World Airways*, the taxpayer had an obligation to perform and pay for overhauls on airplane engines and frames in the future, but only if the airplanes continued in service long enough to log enough flight hours so that the overhaul was in fact due. Furthermore, the taxpayer had contracted with third parties to perform the overhauls, and the taxpayer was only liable to pay for overhauls actually performed.

Obviously, these three cases are totally inapposite to the instant case. In each of these cases, a future event had to happen before any underlying liability came into existence. That is not the case here. Once the employee had been to the doctor and received the medical services, the underlying liability attached. All that remained to be done was the clerical process of calculating the amount of the payment under the terms of the plan. The employee did not have to survive and be living as of the payment date, as in *Trinity Construction*. Nor did he have to continue in taxpayers' employ until payment, as in *Bennett Paper*. The medical services had already been rendered and received by year-end. Taxpayers are not trying to deduct in 1972 an estimate for medical services to be performed in later years, as in *World Airways*.

Thus, the instant case, far from being in conflict with the decisions cited by the government, is in fact in har-

mony with them. Future, contingent liabilities are not presently deductible, while existing and fixed liabilities are. As the trial court found and the appellate court affirmed, the liability for medical services received before the end of 1972 was a current, fixed liability and thus deductible in 1972.

III. THIS CASE DOES NOT MERIT REVIEW BY THIS COURT.

The government argues that this case, because of its supposed broad application in the medical benefits area and beyond, is so important that it requires review by this Court. This is just not so.

This case is apparently the first case to deal directly with a liability for medical benefits. But in reaching their decisions, the courts below relied specifically on the factual record in this case and upon application of well-established case law. Neither court wrote an expansive opinion going beyond the facts of this case. Neither court held that any and all medical benefit plan liabilities are deductible. Neither court held that any and all reserves for unfiled or unprocessed claims are deductible. Neither court held that a reserve for future contingent expenses is deductible. It is just too soon to tell whether this case will have any broad impact.

The government says it has 57 other cases involving similar medical benefit issues. If that is true, the lower courts should evaluate the factual bases of the claims and the respective arguments in more cases before this Court steps into the issue. If, as the government suggests, many claimed deductions for medical benefits do not satisfy the "all events" test, the government will presumably prove that on the record in other cases and either win in the

lower courts or come to this court with a factual record which supports reversal. In any event, the government's Petition for a Writ of Certiorari here is premature. Review at this stage would be ill-advised.

IV. THE DECISIONS BELOW WERE CORRECT.

Whatever surface appeal the government's Petition for a Writ of Certiorari might have comes from its grossly inaccurate presentation of the evidence in the record. The government largely ignores the well-supported findings of the trial court as well as the extensive evidence adduced by taxpayers to show what the medical benefit plans were and how they actually worked. However, the findings are not clearly erroneous and, having been accepted by the two courts below, are not subject to review by this Court. *Berenyi* v. *Director, Immigration*, 385 U.S. 630, 635-36 (1967); see, *Anderson* v. *Bessemer City*, ___ U.S. ___, 84 L. Ed. 2d 518 (1985). The evidence and case law fully support the decisions below.

A. Receipt Of Medical Services By Year-End Fixed Taxpayers' Liability.

Taxpayers clearly satisfied the first part of the "all events" test: the liability for medical services already received but not yet paid was a fixed and definite liability at the end of 1972. The medical benefit plans were in existence and were quite specific regarding who was covered, what was covered, and what would be paid. Prior to receipt of medical services, the plans merely represented potential or contingent contract liabilities. But at the time the employee received the medical services, the facts which established taxpayers' liability occurred: at that time, (a) the employee was or was not covered by

the plan; (b) the medical services were or were not covered; and (c) the medical services were received. Upon receipt of the services, taxpayers' liability had ripened and was contingent no longer. Once the services were received, taxpayers could not avoid liability. Subsequent termination of the plans would not terminate liability for past medical services. If an employee's employment ceased, taxpayers still had to pay for medical services received prior thereto. And the liability existed regardless of whether the claim form had been filed and/or processed before plan termination or termination of employment.

Thus, as the trial court properly held, once the medical services were received, the underlying liability was fixed; the fact of liability was established. (App. 11a-15a.)

B. The Fact That Claims Had To Be Filed And Processed For Payment Did Not Make Taxpayers' Liability Contingent Or Contested.

The government has argued that taxpayers' liability was contingent, potentially available for contest, and not fixed and certain until an employee's claim was filed and fully processed. That argument is contradicted by the trial court's findings, which are correct and certainly not clearly erroneous.

While it is true that claims were not paid until processed, this does not mean that taxpayers were not liable for the purposes of the "all events" test until processing was completed. Liability was not based in any way whatsoever upon fault or wrongdoing by taxpayers; and no adversary was seeking to impose an unwanted liability onto taxpayers. Instead, claims processing was merely a mechanism to calculate the exact amount of a liability taxpayers had already agreed in advance to pay. Claims were

processed by the thousands in a routine, repetitive, systematized, clerical procedure. Based on the evidence presented at trial, the trial court correctly concluded that "defendant's emphasis on the claims-processing procedure is misplaced." (App. 11a.)

While claims processing served a verification function and was the mechanism by which the dollar amounts of the benefit calculations were made, the processing was not a set of "future events" which substantively determined the fact of liability. All of the facts upon which the processors based their calculations had already occurred before the process began. The doctor had been visited, the services had been performed, and the charges for the services could be determined. The processor merely had to match the charges against the plans' benefit schedules. Indeed, if the processor were physically at the doctor's office when the patient left, the calculation of the benefit payment could have been made on the spot.

The Treasury Regulation and relevant cases clearly establish that taxpayers' liability for services received in 1972 was fixed by the end of 1972 and that the filing and processing of claims did not change that result. The seminal case articulating the "all events" test, *United States* v. *Anderson*, 269 U.S. 422 (1926), supports taxpayers' position and was properly relied on by the trial court. (App. 11a-12a.) *Anderson* involved the timing of a deduction for a munitions tax. The tax was based on munitions sold in 1916, but was not assessed, due or payable until 1917. The taxpayer deducted the tax in 1917, but the government asserted that the tax liability accrued before assessment and was deductible in 1916. This Court ruled in favor of the government, stating:

> Only a word need be said with reference to the contention that the tax upon munitions manufactured and

> sold in 1916 did not accrue until 1917. In a technical legal sense it may be argued that a tax does not accrue until it has been assessed and becomes due; but it is also true that in advance of the assessment of a tax, all the events may occur which fix the amount of the tax and determine the liability of the taxpayer to pay it. . . . In the economic and bookkeeping sense with which the statute and Treasury decision were concerned, the taxes had accrued. 269 U.S. at 440-41.

The decision in *Anderson* squarely supports taxpayers' deduction in 1972. Since *Anderson* found that a step as important as assessment of the tax did not defer the deduction, here the filing and processing of the claim is not necessary to satisfy the "all events" test. Relying upon *Anderson*, the trial court correctly held that claims processing was the type of "administrative" or "ministerial" step which does not delay the fixing of liability under the "all events" test. (App. 11a-12a.)

The decisions below are also consistent with this Court's opinion in *Continental Tie & Lumber Co.* v. *United States*, 286 U.S. 290, 295-98 (1932). There a present accrual was held to be required for an award which had not yet been made by the Interstate Commerce Commission (and was therefore yet in an undetermined amount) pursuant to a newly enacted statute. Clearly, claim processing, involving calculations and evaluation, still had to occur before an award was ultimately made. This Court concluded that the Commission's function was ministerial and thus did not preclude accrual.

More recent cases demonstrate that liability may be fixed for the "all events" test even though payment depends upon future events much more significant than the filing of claims and processing of paperwork. In the area of workmen's compensation liability (where state stat-

utes impose liability for occupational injuries to employees with detailed benefit schedules for medical treatment, lost wages and permanent disability payments), courts have found that the taxpayer's liability became fixed for purposes of the "all events" test at the time the employee was injured and before rendition of medical services. *Crescent Wharf & Warehouse Co.* v. *Commissioner*, 518 F.2d 772 (9th Cir. 1975); *Kaiser Steel Corp.* v. *United States*, 717 F.2d 1304 (9th Cir. 1983); *Imperial Colliery Co.* v. *United States*, 599 F.Supp. 653 (S.D.W.Va. 1984).

In the strip mining cases (where by state statute a strip miner had the obligation to backfill and restore the land after mining), the courts have held that the taxpayers' liability attached for the purposes of the "all events" test at the time the mining occurred even though the work to backfill the land would not be performed until a future year. *Harrold* v. *Commissioner*, 192 F.2d 1002 (4th Cir. 1951); *Denise Coal Co.* v. *Commissioner*, 271 F.2d 930, 934-37 (3rd Cir. 1959); *Ohio River Collieries Co.* v. *Commissioner*, 77 T.C. 1369 (1981).

The instant case is a stronger and easier one for a deduction than either the workmen's compensation or strip mining cases, where a deduction was allowed for services to be performed in the future. Here, the medical services have been received by the end of 1972.

In addition to its "contingent claim" argument, the government has suggested that liability cannot exist until processing is complete because there might be some contested claims. This is another position which ignores reality. The fact is that medical benefit claims were not contested. The uncontradicted testimony was that medical benefit claims processing was nonadversarial and did not result in disputes. As the trial court found, claims were

processed to pay the employees all they were due under the plans. (App. 12a.) To the extent medical bills were not paid in full, it was because the plans covered most but not all expenses (*e.g.*, semi-private room costs rather than private room costs). The evidence was that there were only two lawsuits regarding taxpayers' medical benefits in ten years.

Liabilities must actually and affirmatively be disputed to make them contested and thus nondeductible. *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516, 519 (1944). Treasury Regulation § 1.461-2(b)(2) defines "contest" as requiring a "bona fide dispute" and an "affirmative act denying" the liability. (See Addendum.) The trial court properly rejected the government's argument on this point, both factually and legally. (App. 12a-13a.) Indeed, on appeal, the government conceded that these claims were not contested. (Government's Reply Brief p. 6.)

C. Taxpayers' Liability Was Fixed Even Though They Did Not Know All Claimants And Amounts At Year-End.

The government argues that liability is not fixed because taxpayers did not know the precise identity of all the employees who had received medical services by year-end and the amounts of each claim. Of course, taxpayers knew the names of those employees who had submitted forms which were undergoing processing. While taxpayers did not have this knowledge for those employees who had not yet filed claims, this fact is irrelevant.

The liability at issue is not for services to be performed in the future for employees whose identity will be determined by future events. (Tr. 146, 228-229.) Here, the lia-

bility was fixed because at the end of 1972 services had in fact been received by specific, identifiable persons who were members of a fixed group: taxpayers' covered employees and their eligible dependents. Taxpayers did not know all of the names only because they had not collected this information. But since the services had been received, the liabilities to specific people were fixed; their identities were knowable. Taxpayers could have canvassed all of their employees in December of 1972 and ascertained who had claims for medical benefits which had not yet been filed. This clearly satisfies the legal requirements. *Uncasville Mfg. Co.* v. *Commissioner*, 55 F.2d 893, 895 (2d Cir. 1932).

A number of cases have previously established that taxpayers did not need to have a roster of the actual names of all persons receiving medical services in 1972. In each of these cases, the government's arguments that uncertainty as to persons to be paid, time of payment and amount to be paid to each person made liabilities contingent and nondeductible were rejected, even when these facts were not only unknown but unknowable. *Washington Post Co.* v. *United States*, 405 F.2d 1279 (Ct. Cl. 1969) (accrual for liability for amounts due a profit-sharing plan which amounts were not vested for any person); *Lukens Steel Co.* v. *Commissioner*, 442 F.2d 1131 (3d Cir. 1971) (accrual for liability for amounts due in future to supplemental unemployment benefits plan which would pay benefits to workers laid off in the future); *Inland Steel Co.* v. *United States*, 212 Ct. Cl. 558 (1976) (also an accrual for a supplemental unemployment benefit plan).

Contrary to the government's argument, taxpayers in this case are not attempting to deduct future, contingent liabilities based on the excuse that they are able to estimate the amount with reasonable accuracy. They are not seeking to deduct in 1972 the amount of medical expenses

to be incurred in 1973 for services received in 1973 on the theory that they can reasonably estimate what that amount will be. Instead, taxpayers are seeking a deduction in 1972 for existing liabilities for services received in 1972. These services had already been received by specific individual employees. Any additional requirement that taxpayers actually have a roster of the specific names and amounts by year-end is unnecessary to satisfy the "all events" test and would be unreasonable. A deduction should not depend on the size of the taxpayer; yet that would be a result of such a requirement. Taxpayers had approximately 56,000 employees in 1972. (C.A. App. 23-24.) They could have, but did not, collect the names of persons receiving medical services by year-end. That would have been a burdensome expense. But an employer with 100 employees could easily and inexpensively collect such names at year-end and take the deduction according to defendant's position. Such a result is irrational and unjustifiable.

D. Payment Does Not Have To Be Presently Due.

The government really seeks to impose on accrual-basis taxpayers the cash basis of accounting for their expenses. The cases show that, as here, the government is typically arguing that some step must be taken or some fact must yet occur before a deduction is proper. In reality, the government is not satisfied until payment has actually been made or is ready to be made.

But Treasury Regulation § 1.461-1(a)(2) and the cases do not require taxpayers to be on the cash method of accounting for expenses. The decisions of this Court clearly establish that payment does not have to be presently due in order to deduct an existing, fixed and certain liabil-

ity. *United States* v. *Anderson*, 269 U.S. 422, 441 (1926); *American National Co.* v. *United States*, 274 U.S. 99, 105 (1927); *Brown* v. *Helvering*, 291 U.S. 193, 200 (1934).

Thus, the government's argument that there may be a hypothetical employee who waives his benefits by failing to submit a claim form for medical services received is irrelevant. The argument is contrary to this Court's holding in *Anderson*. The possibility in *Anderson* that the munitions tax might never be assessed is at least as great as the possibility that employees might not claim their benefits. Yet this Court treated the argument that the tax did not accrue until assessment as "technical" and disposed of it summarily. Furthermore, this waiver argument would, if accepted, eliminate deduction for any accrued but unpaid expenses. Until actual payment, the recipient could always waive his right no matter how fixed the liability. Consequently, this argument would eliminate completely the accrual basis of accounting for expenses.

* * * * *

The trial court properly held that the taxpayers satisfied the first part of the "all events" test. (App. 15a.) That conclusion was supported by the facts of this case and established case law.

V. THE GOVERNMENT'S RED HERRINGS.

In urging this Court to review this case the government makes arguments about repealed Section 462 of the Internal Revenue Code, special provisions of the Code applicable only to insurance companies, and the distinctions between financial accounting and tax accounting. These arguments are red herrings.

Congress did enact and then repeal Section 462, which allowed ordinary taxpayers to deduct currently certain

general categories of expenses which did not satisfy the "all events" test. But this is irrelevant to the instant case. So long as the present test for deductibility (the "all events" test) is met, a liability must be deducted. Both lower courts properly found that taxpayers' liability met the current test.

It is also true that there are special provisions for deductions of reserves by insurance companies. But again this is irrelevant to this case. Taxpayers did not claim that they were entitled to their deduction because they were de facto insurance companies. Having satisfied the test for deductions by ordinary taxpayers — the "all events" test, taxpayers were entitled to their deduction.

The government also argues that reserves which are prudent for accounting purposes may not meet the requirements for a tax deduction. True, but irrelevant. This deduction is properly based on existing legal standards, not financial accounting rules.

The government's argument on these points boils down to the proposition that if an item can be called a "reserve," it is not deductible, and the government wins. However, this labeling game is phony; the issue is whether the "all events" test is satisfied. In *Anderson*, the seminal "all events" case, this Court held that a "reserve for taxes" was deductible. As the Tax Court has stated:

> "Simply using the term ["reserve"] to describe the deductions in issue is insufficient. . . . Where, as in the current case, the liability in question satisfies both requirements of the all events test, accrual is proper despite the label used by [the government]." *Buckeye International, Inc.* v. *Commissioner*, 49 T.C.M. 376, 385 (1984).

VI. THIS CASE IS NOT GOVERNED BY THE *HUGHES PROPERTIES* CASE.

The government seeks to buttress its request in this case by pointing to the case of *Hughes Properties, Inc.* v. *United States*, 760 F.2d 1292 (Fed. Cir. 1985), which is pending before this Court (No. 85-554) on the issue of deductibility of progressive jackpots on slot machines. In *Hughes*, "progressive jackpots"—jackpots which increase in size as the machine is played—are on slot machines at year-end and are meant to be won by a player in the future.

As conceded by the government, *Hughes* does not control this case. (Petition p. 20.) The slot machine case is clearly distinguishable on many points from the instant medical benefits case.* First, as the government emphasizes in *Hughes*, no player has, in fact, pulled the handle and won the jackpot. The players who played the machine up to the end of the year and who did not win the jackpot have no claim and will never have a claim against the casino. In *Hughes*, the government expresses great concern that at year-end, there is no winning player to enforce the jackpot liability. In the instant case, the employees have already been to the doctor and received services before year-end. Consequently, these people exist to enforce the liability. If their employment is terminated, they still can enforce the liability for medical services received while employed. If the plan is terminated, employees who have already received services can enforce that liability. Secondly, in this case, there is clearly no opportunity for tax manipulation at the discretion of the

* The *Hughes Properties* case was in direct conflict with *Nightingale* v. *United States*, 684 F.2d 611 (9th Cir. 1982). In the instant case, however, there is no conflict among the circuits.

taxpayers. The government expresses concern in *Hughes* that the casino is free to put extra slot machines on the floor at year-end to increase the progressive jackpot liability, and that the casino can set the odds on the machine so it is not likely to pay out for a very long time. Whatever the merit or lack of merit of this argument in *Hughes*, no such manipulative control is available to the taxpayers here. The employees have been to the doctor by year-end, and the medical services which they received are fixed. Clearly, any possible finding of nondeductibility in *Hughes* would not control this case.

CONCLUSION

For the reasons stated above, this case does not merit review by this Court, and a Writ of Certiorari should not be granted.

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ADDENDUM

Treasury Regulation § 1.461-2(b)(2): "Any contest which would prevent accrual of a liability under Section 461(a) shall be considered to be a contest in determining whether the taxpayer satisfies paragraph (a)(1)(i) of this section. A contest arises when there is a bona fide dispute as to the proper evaluation of the law or the facts necessary to determine the existence or correctness of the amount of an asserted liability. It is not necessary to institute suit in a court of law in order to contest an asserted liability. An affirmative act denying the validity or accuracy, or both, of an asserted liability to the person who is asserting such liability, such as including a written protest with payment of the asserted liability, is sufficient to commence a contest. Thus, lodging a protest in accordance with local law is sufficient to contest an asserted liability for taxes. It is not necessary that the affirmative act denying the validity or accuracy, or both, of an asserted liability be in writing if, upon examination of all the facts and circumstances, it can be established to the satisfaction of the Commissioner that a liability has been asserted and contested."